DATE RECEIVED: _____ COMPLAINT NO.: _____

KENTUCKY BOARD OF RESPIRATORY CARE COMPLAINT FORM

Send to: Kentucky Board of Respiratory Care 2365 Harrodsburg Rd., Suite B350
Lexington, KY 40504-3335 or Fax to 859-246-2750

Person / Hospital Filing Complaint

Name:
_____

Address: _____ City: _____ State: _____ Zip Code ____

Work Phone: ( ) - _____- _____ Home: ( ) - _____- _____

Patient Information

(if different from person filing complaint)

Name:
_____

Address: _____ City: _____ State: _____ Zip Code ____

Day Telephone: ( )_____ Evening Telephone: ( )- _____- _____

Relationship to person filing complaint:

_____

Name of licensed respiratory therapist named in complaint

Name:
_____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: ( ) - _____- _____ Home: ( ) - _____- _____

Nature of the complaint

Drug Impairment __ Falsification of documents __ Profession conduct __

Working w/o or expired licensure __ Other __ (Provide as much detail as possible.)

Name and phone number of persons who may provide additional information

1. Name _____ Telephone: ( )_____ Type of Information _____

2. Name _____ Telephone: ( )_____ Type of Information _____

3. Name _____ Telephone: ( )_____ Type of Information _____

Brief Summary of Complaint

(Please be as specific as possible regarding names, dates, locations and actions which you believe to be improper, unethical or unprofessional.)

By signing this complaint form, I herby certify that the information is complete and true to the best of my knowledge.

Signature: _____ **Date:** _____

Kentucky Board of Respiratory Care
2365 Harrodsburg Rd., Suite B350
Lexington, KY 40504-3335
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Email: peggyl.moore@ky.gov